

# HEALTH QUESTIONNAIRE

**Instructions:** Complete this form prior to your physical examination and give it to the examining physician at the time of examination. Answer all questions completely and accurately.

Leave this form (Health Questionnaire Form #BP-8 page 1 & 2) with the physician.

**DO NOT SUBMIT THIS FORM TO POST.**

Applicant's Name ( <i>last, first, middle</i> )				Address			
Date of Birth		Age		Current Occupation			
SECTION A: Have you ever or do you now have any of the following? If you check "YES", supply full details in SECTION B on the reverse side. If the conditions required hospitalization, check the "HOSP" box.							
CONDITION	NO	YES	HOSP	CONDITION	NO	YES	HOSP
1. Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Sensitivity to Dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Back Trouble or Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Any Defect of Bones or Joints. Inc: Amputations, Dislocations, Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Any Complications From Childhood Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Lameness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Rheumatism or Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Cancer or Malignancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Trick or Locked Knee/Knee Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. Tumor, Growth or Cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Eye Injury, Surgery, Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever Worn Glasses or Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32. Pernicious Anemia, Leukemia, or Other Blood Disorder or Ailment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Hearing Impaired or Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Heart Trouble Including Circulatory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever Worn a Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34. High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35. Hepatitis, Jaundice, or Other Blood Disorder or Ailment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Mental Illness or Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36. Diabetes or Sugar in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Addiction to Drugs or Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. Ulcers or Other Stomach Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Fainting or Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38. Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Epilepsy or Fits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Any Disorder of the Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40. Kidney or Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Tuberculosis or Other Lung Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41. Piles or Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42. Rupture or Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43. Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44. Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Poison Oak or Poison Ivy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	45. Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Skin Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## HEALTH QUESTIONNAIRE

	NO	YES
46. Have you ever had or been advised to have an operation? If "YES" give the nature and date(s) of operation(s).	<input type="checkbox"/>	<input type="checkbox"/>
47. Have you ever been a patient (committed or voluntary) in a mental hospital? If "YES" give reasons, date(s) and place(s).	<input type="checkbox"/>	<input type="checkbox"/>
48. Have you had any other illness, injury, or physical condition not named above, other than childhood diseases or minor illness?	<input type="checkbox"/>	<input type="checkbox"/>
49. Have you had an injury within the last 5 years which caused you to lose time from work?	<input type="checkbox"/>	<input type="checkbox"/>
50. Have you ever been denied employment or insurance for medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>
51. Have you ever been deferred from military service for medical, emotional, or health reasons?	<input type="checkbox"/>	<input type="checkbox"/>
52. Have you ever been discharged or released from employment or from the Armed Forces for medical, emotional, or health reasons?	<input type="checkbox"/>	<input type="checkbox"/>
53. Have you ever received or applied for pension or compensation for a disability or injury?	<input type="checkbox"/>	<input type="checkbox"/>
54. Are you presently under a doctor's care for any condition?	<input type="checkbox"/>	<input type="checkbox"/>
55. Have you taken medication within the last 12 months for any reason? If "YES" explain.	<input type="checkbox"/>	<input type="checkbox"/>
56. Do you have or have you ever had any physical or emotional limitations? If "YES" explain.	<input type="checkbox"/>	<input type="checkbox"/>
57. Do you have any impediments of your sense of smell? If "YES" explain.	<input type="checkbox"/>	<input type="checkbox"/>
58. Do you have any impediments of your sense of touch? If "YES" explain.	<input type="checkbox"/>	<input type="checkbox"/>
SECTION B: Write your own account and explain all items answered "YES" in this questionnaire. Identify item by number, include diagnosis, date of onset, and your present condition. Continue on another piece of paper, as needed, and attach.		
Item ##	Explanation (Attached additional pages to the back of this form if needed)	
<p>CERTIFICATION: I hereby certify that there are no willful misrepresentations, omissions, or falsifications in the forgoing statements and answers to questions and that all statements and answers are true and correct to the best of my knowledge and belief.</p> <p><b>I UNDERSTAND THAT I MUST LEAVE THE HEALTH QUESTIONNAIRE (Form BP-8 page 1&amp; 2 and any attached supplemental pages) WITH MY PHYSICIAN.</b></p> <p>Signature of Applicant _____ Date _____</p>		